

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08393

Reg. Dist. No. 357

1. PLACE OF DEATH:

County Worcester
 City or town Snow Hill Rural #1
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Snow Hill Rural #1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Sosby Anderson

3. (b) Social Security Number

none

Sex Female 5. Color or race Belgian 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife George Anderson
 7. Birth date of deceased (mo., day, yr.) August 13/1892 6. (c) If alive, give age _____ years
 8. AGE: Years 55 Months 1 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Conway, South Carolina
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Cornfield
 12. Name Arthur Nickman
 13. Birthplace South Carolina
 14. Maiden name Placenta Bellamy
 15. Birthplace South Carolina
 16. Informant Arthur R. Nickman
 Address Snow Hill, Md Rural #1
 17. (Burial, cremation, or removal. Which?) Oct 13/47
 Date thereof _____ (month) _____ (day) _____ (year)
 Cemetery or crematory St Paul Baptist
 Location Conway, South Carolina
 18. Funeral director Edley C. Dymms
 Address Snow Hill, Md
 19. 930 47 Edley Smith
 (Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 19 47, at 1:45 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 47 to Sept 29 19 47
 and that I last saw her alive on Sept 25 19 47
 Immediate cause of death Pulmonary Tuberculosis DURATION 2 mos
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Paul Chen M. D. M. D.
 Address Snow Hill Date signed 9/30/47

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OCT 3 1947

STANDARD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

466

08394

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 33 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Eugene Harrison Benson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Mary F. Benson

7. Birth date of deceased (mo., day, yr.)

April 20, 1880

6.(c) If alive, give age

67 years

8. AGE:

Years

Months

Days

If less than one day

6755

hrs.

min.

9. Birthplace

Berlin, Talbot Co. Md.
(Town, county, and state)

10. Usual occupation

Jeweler & Watchmaker

11. Industry or business

FATHER
MOTHER

12. Name

Samuel Alexander Benson

13. Birthplace

Maryland

14. Maiden name

Anna Augusta Harrison

15. Birthplace

Maryland

16. Informant

Mrs. E. H. Benson

Address

Berlin Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

9/25/47
(month) (day) (year)

Cemetery or crematory

Engelgreen

Location

Berlin Md.

18. Funeral director

Anna P. Benbow

Address

Berlin Md.

19.

9-27
(Date rec'd by registrar)

19

47Helen F. Hayward

Registrar

23. SIGNATURE

Chas. R. Low MD
M. D. or other

Address

Berlin Md.Date signed 9-27-47

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1947, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1947, to Sept 25 1947
and that I last saw him alive on 9-25 1947

Immediate cause of death

Carcinoma of
Stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date ofWhere did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Chas. R. Low MD
M. D. or other

Address

Berlin Md.Date signed 9-27-47

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Handwritten text, possibly a date or reference number, located in the upper right corner.

Handwritten text, possibly a title or subject line, located in the center of the page.

Handwritten text, possibly a date or reference number, located in the center-right area.

RECEIVED
OCT 2 1947
BUREAU

Handwritten text, possibly a signature or name, located in the lower right area.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08395

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town Ocean City
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 42 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WorcesterCity or town Ocean City
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Annie Parker Bradford.

3.(b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow6.(b) Name of husband or wife Thomas Bradford.7. Birth date of deceased (mo., day, yr.) May 19, 1850 6.(c) If alive, give age _____ years8. AGE: Years 67 Months 3 Days 28 If less than one day _____ hrs. _____ min.9. Birthplace Berlin Md RFD -
(Town, county, and state)10. Usual occupation Housewife.

11. Industry or business

12. Name John B. Bradley.13. Birthplace md.14. Maiden name Sally Mary Holway.15. Birthplace md.16. Informant Mrs. Wm. Parker.Address Ocean City md17. Burial Date thereof 9/20/40
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EvergreenLocation Berlin md.18. Funeral director Annie A. BurbageAddress Berlin md.19. 9-20 47 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 19 47, at _____ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 46 to Sept 17 19 47
and that I saw her alive on Sept. 17 19 47Immediate cause of death Carcinoma of cervix DURATION 18 mos

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Nathaniel Thomas M. D. or otherAddress Ocean City, md Date signed 20/47

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SEP 24 1947

BUREAU 73

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0839650

1. PLACE OF DEATH:

County Worcester
 City or town Rural, Pocomoke md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 84 years
 Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Worcester
 City or town Rural, Pocomoke md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John Handy Brittingham

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Color

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Mary Brittingham

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

July 1 - 1863

8. AGE:

Years

Months

Days

If less than one day

8420

hrs.

min.

9. Birthplace

Pocomoke Worcester md
(Town, county, and state)

10. Usual occupation

Farming

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

"

MOTHER

14. Maiden name

unknown

15. Birthplace

16. Informant

Address

Bowena Cropper
Rural Pocomoke md

17.

(Burial, cremation, or removal, which?)

Date thereof

Sept 3 - 1947
(month) (day) (year)

Cemetery or crematorium

St James Cemetery

Location

Rural Pocomoke md

18. Funeral director

Address

Shirley T. Tilton
Pocomoke md

19.

(Date rec'd by registrar)

19

47Anne E. White
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 1 1947 at 5: P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 1947 to Sept 1 1947
and that I last saw him alive on Sept 1 1947

Immediate cause of death

Myocardial degeneration

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

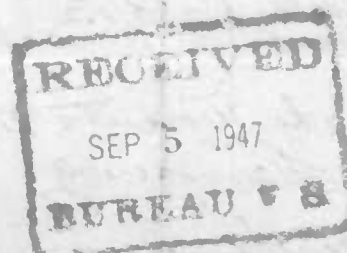
23. SIGNATURE

M. D. or other

Address

Date signed

9-2-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08397

Reg. Dist. No. 357

1. PLACE OF DEATH: Worcester
County.....
City or town..... Snow Hill Rural #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 2 days
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Worcester
City or town..... Snow Hill Rural #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war..... 70

3. (a) FULL NAME Charles A. ~~Smith~~ Clark
3. (b) Social Security Number none

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife.....
7. Birth date of deceased (mo., day, yr.) Sept. 11 - 1947
6.(c) If alive, give age..... years
8. AGE: Years 0 Months 0 Days 3 If less than one day hrs. min.
9. Birthplace Snow Hill, Worcester, Md.
(Town, county, and state)

10. Usual occupation.....
11. Industry or business.....
12. Name..... Andrew C. Callum
13. Birthplace Maryland
14. Maiden name..... Selma Daley
15. Birthplace Maryland
16. Informant..... Andrew C. Callum
Address..... Snow Hill, Md Rural #2
17. (Burial, cremation, or removal. Which?) Burial Date thereof..... Sept. 13/47
(month) (day) (year)
Cemetery or crematory.....
Location..... Snow Hill, Md Rural #2
18. Funeral director..... Elmer C. Dumas
Address..... Snow Hill, Md
19. 9/13/47 19 47 LeRoy Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 13 19 47 at 8:20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 11 19 47 to Sept 13 19 47
and that I last saw him alive on Sept 12 19 47
Immediate cause of death..... Bronchopneumonia
DURATION 2 days
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)
Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?
23. SIGNATURE..... Robert L. LaMar M.D. or other
Address..... Snow Hill Date signed 9.13.47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

08398

355

1. PLACE OF DEATH:

County... Washington
 City or town... Ocean City
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: noHow long in hospital or institution? no

3. (a) FULL NAME

Bettie Dennis4. Sex female 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced Divorced8. (b) Name of husband or wife noDon't know 8. (c) If alive, give age Don't know years7. Birth date of deceased (mo., day, yr.) OK except from 19458. AGE: Years not born Months OK Days OK If less than one day OK hrs. min.9. Birthplace Berlin and
(Town, county, and state)10. Usual occupation Housekeeper11. Industry or business same as above12. Name Joseph Dennis13. Birthplace Berlin and14. Maiden name Mary Parthey15. Birthplace Berlin and16. Informant Samuel DennisAddress Ocean City, Md.17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept 8 1947Cemetery or crematory EvergreenLocation Berlin and18. Funeral director James P. StewartAddress Salisbury and19. 9-8 19 47 John F. Hayward

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WashingtonCity or town Berlin and R.F.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. no
(If rural, give LOCATION)2. (a) If veteran, name war no

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 19 47 at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...Immediate cause of death DKDue to Probably coronary occlusionDue to hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury 11 E system Injured at work?23. SIGNATURE John F. Hayward M. D. or otherAddress Ocean City, Md. Date signed 9/5/47

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SEP 10 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08399

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:

County Worcester
City or town Cradle Tree Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Cradle Tree Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Annie Maria Douglas

3. (b) Social Security Number

4. Sex Female 5. Color or race colored 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife John Silas Douglas7. Birth date of deceased (mo., day, yr.) unknown 1842 6. (c) If alive, give age _____ years8. AGE: Years 85 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name John Becke Hs13. Birthplace Maryland14. Maiden name Harriet (unknown)15. Birthplace Maryland16. Informant Ira Douglas - sonAddress Snow Hill17. Burial Date thereof 9/22/47
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematorium Bohloping, Worcester Co.Location Siddle Tree, Md.18. Funeral director Erwin BennettAddress Stockton, Md.19. 9/22 47 Relay Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 19 47 at 8:15 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 19 47 to Sept 19 19 47 and that I last saw her alive on Feb 19 47Immediate cause of death Arteriosclerotic Myo-
carditis DURATION unknown

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul Chen M.D. M. D. or other _____Address Snow Hill Date signed 9/20/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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SEP 25 1947

BUREAU # 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08460

Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
 City or town Rural Pocomoke Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Grace Mildred Duran

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

E. C. Duran

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

27 1 6 hrs. min.9. Birthplace Anderson, Rusk, Texas
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Samuel T. Ballenger

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, Which?)

Date thereon Sept 28, 1947
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19 47Anne E. White
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Texas County RuskCity or town Anderson, Texas
(If outside city or town limits, write RURAL and give nearest town)Street No. 205 Hall Street
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23, 1947 at 4:19 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Sept 19 47 to 22 Sept 19 47 and that I last saw ER alive on 22 Sept 10:30 AM 19 47

Immediate cause of death

Coronary Thrombosis, D.H.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. S. Kelly, M.D.
Address Chickering Road Date signed 23 Sept 47

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SEP 25 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08401 355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin RFD Parkersburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 44 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Jackson Hadden4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Alice Hadden7. Birth date of deceased (mo., day, yr.) Jan 18, 1870 8. AGE: Years 77 Months 8 Days 9 If less than one day9. Birthplace Berlin, Wor. Co. Md.
(Town, county, and state)10. Usual occupation Striker

11. Industry or business

12. Name Stephen Hadden13. Birthplace Berlin Md.14. Maiden name Eliza Reed15. Birthplace Berlin Md.16. Informant Mrs J. J. HaddenAddress Berlin Md RFD17. (Burial, cremation, or removal. Which?) Burial Date thereof 9/29/47
(month) (day) (year)Cemetery or crematory EvergreenLocation Berlin Md18. Funeral director Dr. A. S. BurboAddress Berlin Md19. 9-29-47 Helen F. Hayward Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WorcesterCity or town Berlin RFD
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 September 19 47 at 7:00 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 June 19 47 to 22 Sept 19 47and that I last saw him alive on 27 Sept 47 19 47Immediate cause of death Central ThrombosisDue to Renal arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Herman A. Pullin Jr M. D. or otherAddress 5 Bay St. Berlin Md Date signed 29 Sept 47

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OCT 2 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

08402

351

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

..... hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal) Which?

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

19

47

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

September 12, 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from.....

19.....

to.....

19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

Address.....

Date signed.....

7

RECEIVED

SEP 17 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08403

Reg. Diat. No. 350

1. PLACE OF DEATH:

County Washington
 City or town Pocomoke md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days
 Hospital, institution, or street address where death occurred: -

How long in hospital or institution? -

3. (a) FULL NAME

Melvina Jolly

3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Edward Jolly7. Birth date of deceased (mo., day, yr.) June 6 - 18816. (c) If alive, give age - years8. AGE: Years 66 Months 3 Days 17 If less than one day - hrs. - min.9. Birthplace Plattsburg N.Y.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name unknown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Mrs Jack CustisAddress Pocomoke md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Sept 30 - 1947
(month) (day) (year)Cemetery or crematory Logium WashingtonLocation Logium Washington18. Funeral director John E. WhiteAddress Pocomoke City md19. Sept 25, 47 Anne E. White
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County St. Mary's HarborCity or town Pacific Beach
(If outside city or town limits, write RURAL and give nearest town)Street No. -
(If rural, give LOCATION)2. (a) If veteran, name war -

MEDICAL CERTIFICATION

2D. DATE OF DEATH September 23, 47, at 2:30 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15, 1947 to Sept. 22, 1947
and that I last saw her alive on Sept. 22, 1947Immediate cause of death Coronary Thrombosis DURATION 6 monthsDue to Hypertensive AtherosclerosisDue to Hypertensive Heart Disease 5 yrs.Due to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None Date of op. -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE Louis J. Cleveland, MD M. D. or other -Address Pocomoke City md Date signed 9-25-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town Shoreville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 47 years

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Shoreville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Frank William Leatis

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Gate Leatis7. Birth date of deceased (mo., day, yr.) July 13, 18788. AGE: Years 69 Months 1 Days 18 It less than one day _____ hrs. _____ min.9. Birthplace England
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Frank William Leatis13. Birthplace MD14. Maiden name Anna Latchum15. Birthplace MD16. Informant Mr. John LeatisAddress Shoreville MD17. (Burial, cremation, or removal, Which?) Cremated Date thereof 9/3/47
(month, day) (year)Cemetery or crematory Old FellowsLocation Shoreville MD18. Funeral director James F. BurbageAddress 36 W. Main St.19. 9-2 47 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 19 47 at 1220 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

25 Aug 19 47 to 1 Sep 19 47and that I last saw him alive on 125 Sep 19 47Immediate cause of death CerebralHemorrhage

DURATION

Due to atherosclerosis cerebral 6 yrsgeneralizedDue to hypertension heartfailure

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town) (County) (State)

Injured at home, farm, industry, public place (whore?) _____

Means of injury _____ Injured at work? _____

3. SIGNATURE Herman R. Buler

M. D. or other

Address 5 Bay St. Buler, MD Date signed 24/47

RECEIVED
SEP 6 1947
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08405

Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 weeks
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2114 Maryland Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War #1 ✓

3. (a) FULL NAME

George E. Sletzky
ON Edward George Sletzky

3. (b) Social Security Number

219-05-4298

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Alice E. Sletzky
 6.(c) If alive, give age known years
 7. Birth date of deceased (mo., day, yr.) September 16, 1898
 8. AGE: Years 48 Months 1 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Pittsburgh Pining
 (Town, county, and state)
 10. Usual occupation Accountant
 11. Industry or business

12. Name George Sletzky
 13. Birthplace Pittsburgh Penna
 14. Maiden name Bertha Straube
 15. Birthplace Pittsburgh Penna

16. Informant Mrs Alice E. Sletzky
 Address 2114 Maryland Ave, Balte City, Md

17. Burial Burial Date thereof Sept 12, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cem
 Location Baltimore City, Md

18. Funeral director Henry H. Watson
 Address Pocahontas City, Md

19. Sept. 9 1947 Anne E. Shile
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1947 at 11:50 A
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____,
 and that I last saw h. _____ alive on _____ 19_____.
 Immediate cause of death acute alcoholism
 DURATION 2 days

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE John R. Riley M.D. M. D. or other _____
 Address Shrewsbury, Md Date signed 9/9/47

RECEIVED
SEP 13 1947
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08406

Reg. Dist. No. 351

1. PLACE OF DEATH:

County WorcesterCity or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Annie L. Pettit

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

West Pettit

7. Birth date of deceased (mo., day, yr.)

June 15 - 1880

6. (c) If alive, give age _____ years

8. AGE:

Years 67 Months 3 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace

Accomac Virginia
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Owner

FATHER

12. Name William Taylor13. Birthplace Virginia

MOTHER

14. Maiden name Unknown15. Birthplace "16. Informant Rev Samuel J. PettitAddress Snow Hill, Md17. (Burial, cremation, or removal. Which?) Burial Date thereof Sept. 29/47
(month) (day) (year)Cemetery or crematory Christ BaptistLocation Marysville, Va.18. Funeral director Way E. HarrisAddress Snow Hill, Md19. 9/29/47 47 LeRoy Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1947, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/1/47 to 9/27/47and that I last saw him/her alive on 9/27/47

Immediate cause of death

Arteriosclerosis of myocardium

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

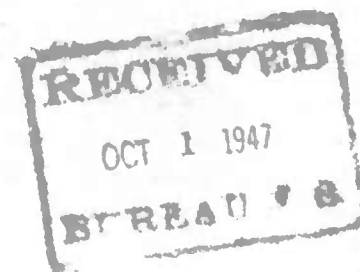
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul Shen M. DAddress Snow Hill Date signed 9/27/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH: Worcester
County Snow Hill
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: R.D. #2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For non-born in state give residence of mother)
State MD County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elijah Wilmer Purdue 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
6.(b) Name of husband or wife Mary Virginia Purdue
7. Birth date of deceased (mo., day, yr.) Sept. 22 - 1866 6.(c) If alive, give age deceased years
8. AGE: Years 80 Months 11 Days 27 If less than one day hrs. min.
9. Birthplace R.D. Paromonty Md.
(Town, county, and state)

10. Usual occupation retired
11. Industry or business Farmer
12. Name John James Prettyman Purdue
13. Birthplace R.D. Paromonty Md.
14. Maiden name Mary Hester Ennis
15. Birthplace R.D. Paromonty Md.

16. Informant Mrs. Cora Pursey
Address R.D. #2 Snow Hill Md.
17. Burial, cremation, or removal (Which?) Buried Date thereof Sept 21-47
(month) (day) (year)
Cemetery or crematory Worcester Co. Md.
Location Worcester Co. Md.

18. Funeral director William H. Walter R. Walters
Address Salebury Md.
19. 92 of 1947 LeRoy Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1947 at 47 215 p
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Sept 19 1947
and that I last saw him alive on Sept 18 1947
Immediate cause of death Arterio-sclerosis
myocardial
Due to
Due to
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul Chen M D
Address Snow Hill Md Date signed 9/25/47
M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 22 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 354

1. PLACE OF DEATH:

County Worcester
City or town Rural, Stockton md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Rural, Stockton md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Myrtie H. Pilchard

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white Widowed

6. (b) Name of husband or wife John G. Pilchard

7. Birth date of deceased (mo., day, yr.) Feb. 13 - 1884

8. AGE: Years Months Days If less than one day

63 7 16 hrs. min.

9. Birthplace Pocomoke, Worcester md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John W. Holland

13. Birthplace Maryland

14. Maiden name Laura A. Rolan

15. Birthplace Maryland

16. Informant Mrs. Frank Taylor

Address Stockton md.

17. Burial Date thereof Oct 2 - 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium Gordonsville Cemetery

Location Rural, Pocomoke md.

18. Funeral director Sherry Robinson

Address Pocomoke md.

19. Oct 2 19 47 Mary M. Taylor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1947 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 45 to Sept 29 19 47

and that I last saw him alive on Sept. 29 19 47

Immediate cause of death

Cerebral Vascular Accident 1 Hour

Due to Previous Cerebral Vascular 16 days

Due to accident.

Due to Hypertensive Cardiovascular 10 days

Due to renal disease.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul L. Le Mar MD
M. D. or other

Address Snaukeville Date signed 10-2-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REC'D
OCT 6 1947
BUREAU V C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

357

1. PLACE OF DEATH:

County Worcester
City or town Snow Hill Rural R # 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
City or town Snow Hill R # 2 Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2(a) If veteran, name war no

3. (a) FULL NAME

Betty Anne Taylor

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced single
6. (b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) Sept 22, 1947 6. (c) If alive, give age years
8. AGE: Years Months Days If less than one day
2 hrs. min.

9. Birthplace Snow Hill Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name George Wm Taylor
13. Birthplace Maryland
14. Maiden name Hattie Anne Fisher
15. Birthplace Maryland

16. Informant Geo Wm Taylor
Address Snow Hill

17. Burial Date thereof Sept 25/47
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Good Springs
Location Snodgrass Md

18. Funeral director Ray C. Dinning
Address Snow Hill, Md

19. 925 19 47 LeRoy Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 19 47, at 2:00 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 24 19 47, to Sept 24 19 47, and that I last saw h. not seen alive alive on 19

Immediate cause of death Fatal Hemorrhage from umbilical cord due to rupture of umbilical artery.
DURATION 1 day

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul Cohen M D M. D. or other
Address Snow Hill Md Date signed 9/25/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 27 1947
BUREAU

Mr. C. W. Brown
New York City

Received
Sept 26 1947

Very truly yours,
John H. Brown

Sept 26 1947

RECEIVED
SEP 26 1947
BUREAU # 8

John H. Brown
New York City
Sept 26 1947
Bureau # 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as to sex, age, date, and cause of death. Write the causes of death clearly and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08411

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin Md R.T.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WorcesterCity or town Berlin R.T.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Bertha M. West.

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife John West7. Birth date of deceased (mo., day, yr.) July 15, 1895 6. (c) If alive, give age 59 years8. AGE: Years 52 Months 2 Days 7 If less than one day _____ hrs. _____ min.9. Birthplace Chincoteague, Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Daniel J. Borch.13. Birthplace Va.14. Maiden name Mamie Anne Murrell15. Birthplace Va.16. Informant Mr. John West.Address Berlin Md R.T.D.17. Burial Date thereof 9/24/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory RiversideLocation Berlin Md R.T.D.18. Funeral director Anna A. BurbageAddress Berlin Md19. 9-24 47 Helen H. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Sep 1947 at 29 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Sept 22 1947 and that I last saw her alive on 22 Sept 1947Immediate cause of death Heart Disease -Myocardial infarctionDue to _____ DURATION 7m

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Vernon H. Burkhardt M. D. or other _____Address Berlin, Md Date signed 23 Sept 47

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Handwritten notes in the lower middle right section.

RECEIVED
SEP 27 1947
BUREAU

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Handwritten notes at the bottom right of the page.